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THE
CAPE TOWN
CHILD GUIDANCE CLINIC

1935 - 1971

AN HISTORICAL ANALYSIS

By
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for the degree of Master of Arts
in the Department of Psychology
of the University of Cape Town

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ABSTRACT

The study traced certain themes in the history of the Child Guidance Clinic during the period 1935 to 1971, in order to support the following hypotheses: (1) The establishment and development of the Clinic corresponded to the rise and growth of clinical psychology in South Africa. (2) The development of clinical psychology in this country reflected international developments in the field. (3) The practice of psychology was initially ensconced in education. (4) The role of the psychologist expanded in conjunction with the expansion of the psychologists' knowledge base. (5) As a result of the growth in practical and applied psychology, the professionalization of psychology emerged.

The study aligned itself generally with those historiographies that view the history of psychology from a contextual approach. The work of Rose (1985) and Van Hoorn (1983) in particular, broadly informed the way in which the study was approached. Archival data consisting of the Clinic's Annual Reports dating from 1935 to 1972 were used as primary sources. A semi-structured interview was conducted with the past director, Dr. Grover.

The development of the Clinic was placed within the context of the Mental Hygiene Movement of the early 1900s. An analysis of the Clinic's work illustrated its close involvement in education, in the form of identifying "problem" children arising initially mainly from the school. The importance ascribed to intelligence testing was indicated. The subsequent growth of a base of psychological

knowledge and an increased specialist psychological role was then explored in relation to the procedure followed at the Clinic. It was argued that psychologists occupied a dominant position within the Clinic's multi-disciplinary team, their knowledge base became more specialised over time, as shown from an analysis of the classificatory systems used, and that the Clinic succeeded in popularizing psychology to the general public. The development of the Clinic was then placed against the background of the issues of professionalization in South Africa. It was shown how, being situated between university, educational and clinical practice, the Clinic constituted an appropriate setting for the future training of clinical psychologists in South Africa. The developments in clinical psychology in this country were broadly compared to those within the international realm throughout the text.

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Chapter 1

INTRODUCTION

The notion that children need to be guided in one way or another, be it religiously, morally or otherwise, has been an object of concern to adults throughout the centuries. The idea of Child Guidance Clinics, specialised institutions created for the express purpose of guiding children from a psychological point of view, however, is a twentieth century phenomenon.

The first Child Guidance Clinics emerged during the 1920's. In the USA the first of many Demonstration Clinics was established in 1921, with the aid of the Commonwealth Fund (Levine and Levine, 1970). In Britain, the Children's Department of the Tavistock Square Clinic opened in 1926 and the first Demonstration Clinic, also aided by the Commonwealth Fund, was opened in 1928 (Rose, 1985). South Africa was close behind; what were then called Psycho-educational Clinics were opened during the same time, one in Bloemfontein in 1927, followed by one in Pretoria a year later (Minde, 1975d).

The Commonwealth Fund Clinics started as part of a larger programme for the prevention of juvenile delinquency (Levine and Levine, 1970). The British Tavistock model concentrated on a wide range of problems with referrals from and interaction with a variety of institutions (Rose, 1985). Although there were differences between models, child guidance work was characterized generally by

its use of a multi-disciplinary co-operative team, an underlying psychological framework based on psycho-analysis or one of its derivatives, and the underlying aim was preventative, through early identification and intervention (Levine and Levine, 1970).

As regards identification, the recognition of a particular problem, that of "feeble-mindedness", had been an issue in Britain since the turn of the century (Rose, 1985). At this time, a eugenicist strategy was dominant and the identification and categorisation of "feeblemindedness" was advocated as a means of separating out those individuals who were regarded as degenerate stock, for fear of national deterioration. This strategy gradually lost momentum and by 1910 was superseded by that of the Neo-Hygiene Movement.(1)

This movement aimed to promote health as an important social value and as a personal responsibility, via environmental reform through preventative medical assessment and through education. The Mental Hygiene Movement, a derivative of the Neo-Hygiene Movement, addressed social concerns related to that of mental health along the same lines. This preventative strategy called for (1) the early identification and treatment of minor troubles before they could become major mental disturbances, and (2) the promotion of correct mental hygiene habits in the family (Rose, 1985).

In South Africa, as in Britain, the school became one of the first sites of intervention from the Hygiene Movement's perspective. Dr. C.L. Leipoldt was appointed as the first medical inspector of schools in 1915 (Kriek, 1968), and with the introduction of

compulsory education for white children in 1919, the school became the place from which physical defects as well as the "problems" of "feeble-mindedness" and later "difficult behaviour" would emerge on a widespread level.(2)

A new site was needed to deal with these problems, and, in line with the Mental Health strategy, Child Guidance or, what were also aptly termed Psycho-Educational Clinics, were advocated for this purpose. The Cape Town Child Guidance Clinic was thus an outcome of the international Child Guidance Movement of the 1920s and 1930s.

In administrative terms the Cape Town Child Guidance Clinic has undergone many changes since its inception. The Clinic was established in 1935, under the Directorship of Dr. H.A. Reyburn, professor of Psychology at the University of Cape Town. From 1939 to 1956 it occupied a disused Church provided by the Cape School Board in Mowbray.(3) The staff, comprising members of the Psychology Department and voluntary workers, were available for consultation one afternoon a week and met at weekly staff meetings to discuss individual cases. The work was mainly diagnostic and advisory. Services were available to "European" children and were free of charge (Annual Reports, 1937 - 1957).(4)

Dr. Reyburn remained Director until his death in 1950. Dr. E.M. Thompson, Mr J.G. Taylor and Dr. V.M. Grover, all members of the Psychology Department, shared co-directorship for an interim period after which time, in 1952, Dr. Grover assumed full directorship. She remained in this position until her retirement at the end of 1971.

While Dr. Grover was in charge many changes occurred with regard to both the administration and the work of the clinic. In 1957 the clinic was officially placed under the auspices of the Psychology Department of the University. The clinic therefore moved from being a relatively independent, voluntary service organisation to that of an institutionally backed subsidiary with circumscribed functions. These were stipulated as the following:

- (1) providing practical work for under-graduate and clinical training for post-graduate students;
- (2) fostering research in areas pertinent to Child Psychology; and
- (3) maintaining the free service function to the community.

The University assumed basic administrative costs: running costs were covered by annual grants decided by the University and those psychological staff involved in the training/research functions of the clinic were paid by the University. In the same year the clinic moved to new University premises, a building which had been designed and built specially for the purpose in 1956.(5)

The opening paragraphs of this chapter already reflected an implied version of what would be considered as an adequate history of the Clinic. That is, not simply a narrative of dates, names and important events in the development of the Clinic, but one which would include a consideration of the social context within which developments took place.

The social basis and the extra-scientific factors underlying and influencing the discipline of psychology, such as politics,

economics and the social climate, are generally accepted within the social sciences today (Buss, 1975; Kessen, 1979; Lomax, 1978; Newson and Newson, 1974). A number of historiographical approaches are available to guide one's thinking in this regard. For example, a Marxist approach (e.g. Maiers, 1989), a generally "contextualist" approach (e.g. Rose, 1985), an approach known as Transformational Contextualism (e.g. Van Hoorn, 1983) and the rather idiosyncratic work of the Dutch psychiatrist J.H. van den Berg (1961).

The present study is not intended as a methodological exposition, and the debate concerning these approaches will not be discussed here. It should become clear that the general tenets of these historiographies, in particular Rose's and Van Hoorn's work, informed the way in which this study was approached. That is, the social context around which the Clinic, as a particular instance of psychological practice, was established, was considered.

Archival data, in the form of the Annual Reports of the Clinic dating from 1935 to 1972, have been used as primary sources to provide a data base for this study. In addition, a semi-structured interview was conducted with the past director, Dr. V. Grover.

Limiting the data base to these sources was the first decision taken with regard to the scope of the project. Another limitation was in terms of time period. The reasons for the establishment of 1971 as the cut-off date are two-fold. Firstly, on a chronological level, 1971 marks the end of an era for the Clinic with the retirement of Dr. Grover after twenty years as Director. Secondly, this date also represents the start of a new period, in that the

full-time training internships were begun at the Clinic in the following year.

The aim of this study is to trace certain themes discernible in the work of the Clinic, from 1935 to 1971. Although the study remains largely descriptive, the following arguments will be developed in relation to these themes:

1. The establishment and later developments of the Clinic parallel the rise and development of clinical psychology in South Africa.
2. The development of clinical psychology in South Africa mirrors that of developments elsewhere.
3. Practical and applied psychology initially developed out of the field of education in South Africa.
4. The psychologist's role gradually expanded to that of an expert within the educational realm.
5. As a consequence of the issue of professionalization, training and internships in clinical psychology emerged.

The first two hypotheses are referred to generally throughout the text. The remaining suppositions are addressed under separate headings, in conjunction with the work of the Clinic, in the following chapter.

Chapter 2

THE WORK OF THE CLINIC

This chapter outlines the work of the Clinic from its inception until 1971. The areas examined under the descriptive title of "work" comprise the staffing of the Clinic, staff members' particular areas of interest or expertise, and student training, together with the practical work done with children. The reasons why children were referred to the Clinic, by whom they were referred, and the general procedure followed as well as treatment offered, are explored.

These areas, and those changes occurring within them over this time period, are examined under three sections. These subdivisions relate to the hypotheses outlined in Chapter 1: psychology was first and foremost involved in education; psychological expertise developed and changed over time; and finally, the professionalization of psychology.

EDUCATION, THE PRACTICE OF PSYCHOLOGY AND THE CHILD GUIDANCE CLINIC

"The New Education has taken practical shape in the Twentieth Century in the idea of child guidance. In principle there has been a general acceptance of the value of fitting education to the individual on the part of progressive educators for the last two centuries, but it is only within our own times that the principle has made much impression on the practice of home and school."

Dr. William Boyd, 1937, The New Education Fellowship.

Two inter-related developments in South Africa during the 1920s helped to make the emergence of the Child Guidance Clinic possible.

These were the enforcement of compulsory education for whites, together with the rapid development of mental testing.

In 1919 compulsory white education up to Standard 6 or the minimum age of 16 years was introduced in Cape schools. Free schooling in Government schools was made available from the following year (Mathie, 1947). This development resulted in a common evaluation ground for children of the same age and allowed for a comparison of their abilities and behaviour. Schools were faced with the problem of needing to deal with those children unable to fulfill either the intellectual or social demands made on them by the educational system. The term "deviate pupils" was officially assigned to those who, because of so-called physical, mental or behavioural abnormalities, were either unable to benefit from ordinary education themselves or prevented others from doing so (Mathie, 1947). Separate education for "deviates" was advocated and special classes for the mildly retarded were slowly introduced into schools from 1928 (Minde, 1975d). Certification and institutionalization was the aim for the more severely handicapped (Foster, in press).

By 1928 intelligence tests were entrenched as the means of identifying and classifying mentally handicapped children. Prior to this these children were differentiated mainly on the grounds of social or behavioural terms (Foster, in press). The Fick Individual Scale, also known as the Individual Scale of the National Bureau of Educational Research, standardized on white South African children, was available from 1926 and revised in 1939. The South African Group Mental Test was developed in 1931 (Kriek, 1968), to allow for the testing of relatively large numbers of children. (6)

Thus the new knowledge and application of mental tests resulted in a normative classification of the individual, which was predictive of the person's scholastic ability. The introduction of this new technique was significant for another reason as well: it also allowed for the advent of a new "specialist" agent to operate and administer it, - the psychologist. Psychologists were quick to claim these tests as belonging to their field of expertise (they were after all the ones who were developing it), and in doing so, were already drawing the boundaries of exclusive competence.

Apart from mental handicap, the other form of "educational deviancy" that was to be dealt with via psychological means, was that of the so-called maladjusted child. Any "behavioural aberration", be it difficult or unstable behaviour, such as nervousness, excessive emotionality or lying, was reconceived in terms of maladjustment (Rose, 1985). However, while the strategy devised for dealing with mental handicap was that of segregation (Foster, in press), problems of maladjustment were considered differently. They were conceptualized as minor abnormalities, invariably caused by an unsavoury environment, usually that of the home. If not treated early, in childhood and while the child was at school, it was considered likely that they would develop into larger social problems, such as delinquency. The importance attached to these problems was therefore not in terms of the disruption to school, but more in terms of being signs of future major problems (Rose, 1985).

The maladjusted child, like the child with a mental handicap, so became an object for assessment and intervention, from a

psychological point of view, albeit not with the same objective. The Child Guidance Clinic was conceived of as the specialized service, separate from and yet linking home, school and other agencies where these educational problems, in the widest sense of the word, could be evaluated and recommendations made (MacCrone, 1936).

The establishment of child guidance clinics as sites for these kinds of psychological intervention received a major boost in the 1930s. In 1934, a major conference, the New Education Fellowship Conference, was organised in both Cape Town and Johannesburg, with the aim of addressing educational problems pertinent to South Africa (Malherbe, 1937). The importance of Child Guidance Clinics in dealing with childrens' psychological problems was stressed by more than one speaker, and one of the Conference's final resolutions was to establish such clinics all over the country (Boyd, 1937).

Following this Conference, two clinics were started in January 1935: one in Cape Town by Dr. Reyburn, and one in Stellenbosch by Dr. Strassheim. They were professors in the Psychology Departments of the Universities of Cape Town and Stellenbosch respectively (Annual Report, 1935 - 1937). Dr. De Vos Malan, the then new Secretary-General of Education, procured a small grant from the Provincial Education Department to assist the clinics (Minde, 1937a).

This grant, together with one from the University, covered only basic costs such as that of materials. As referred to in Chapter 1, the Clinic itself was run as a volunteer organisation, offering its service free of charge. In the ensuing paragraphs the original

honorary clinic staff will be discussed in order to illustrate psychology's close alliance with education.

Like the overseas clinics, the clinic was run as a cooperative team but was staffed primarily by members of the Psychology Department, together with volunteer helpers. The first Annual Report outlines the honorary positions of a Director, Secretary, Medical Officer, Psychiatrist, Speech and Hearing Specialist and three psychological staff.

Psychological study and pedagogy were closely linked, judging from the psychology staffs' expertise. Professor Reyburn was regarded as a specialist in the educational sphere. His role at the clinic included advising teachers and parents on suitable educational methods (Minde, 1937b). In the 1920s he had played a part in devising the South African Individual Scale Intelligence Test (Rees-Davies, 1930). Prior to the establishment of the Clinic he and other University psychological staff had visited schools in the Peninsula both to administer intelligence tests and also in an advisory capacity (Minde, 1937b).

The theses written by the clinic's psychological staff also indicate the extent of psychology's involvement in the field of education in the first half of this century. Dr. Rees-Davies, in charge of intelligence testing at the clinic, obtained her Ph D at the University of Cape Town in 1930. The topic was a critical analysis of the 1925 provisional South African Individual Intelligence Scale (Rees-Davies, 1930). Similarly, Dr. H.W. Smith (1945) worked on a differential Intelligence and Scholastic Test for

the Child Guidance Clinic in collaboration with Dr. Reyburn. Factors influencing success at school served as the topics for both Dr. E.M. Thompson's doctorate in 1943 and Dr. Grover's Master's thesis. At this time there were also included amongst the psychological staff a certain P.J. Olckers with a Masters degree in Education and another member, a Miss M.H. Lensing with a Special Class Teachers' Diploma from Cape Town University (Annual Report, 1941 - 1943). This Diploma was first introduced at the university in 1939 (Mathie, 1947).

As can be deduced from the above research activities, testing formed a major part of the Clinic's work description from the outset. What follows is a description of work entailed at the Clinic during the first twenty years in order to illustrate further the close link with education. In this section the initial types of "problem" children referred are also discussed and the data regarding referral sources for the first twenty years, as given in the Annual Reports, is analysed.

As stated, a large part of Clinic work in the first years was that of administering intelligence tests, for the purpose of drafting children into special classes. This corresponded with the introduction of special classes in the schools and with the training of such teachers at South African universities. The major focus in education in the 1930s was that of provision for the mentally handicapped and the number of special classes in the Cape increased from 20 in 1932 to 71 in 1937 (Mathie, 1947). Minde (1937a) mentions that as there were so few special classes available, one of

the useful functions of the Clinic was to help school principals select those children that would benefit most.

During the first three years the Clinic staff went to sixteen schools under the Cape Education Department and administered the S.A. Group Test in order to single out those children suspected of being suitable special class candidates (Annual Reports, 1935 - 1937). Private schools were also visited. The Annual Report for 1941 - 1943 mentions psychological staff travelling to Wellington to assess all the children at the Marie Marais Institute for the Mentally Handicapped. This was done at the request of the principal so that the children could be classified according to their mental ability, ostensibly to match work/training requirements to the individual child.

At the Clinic itself, work centered around dealing with children with scholastic as well as behavioural problems, as noted in the school or the home (Annual Reports 1935 - 1951).

Only white problem children were dealt with until 1971, when it became open to all. This indicates the extent to which the practice of psychology was influenced by the wider social context. In South Africa racial segregation was implemented on both a formal and an informal level before World War II. This applied to education as well. The Clinic was linked to the Cape Education Department and was situated in a white middle class area and so served to address the problems of a white, mainly middle class clientele.

The problem children, as outlined by Minde (1937a), the Clinic's first Honorary Psychiatrist, were as follows:

- 1) Mental Defectives, defined as those with an IQ of 70 or below on Terman's Stanford Revision, the test used at the Clinic at the time.
- 2) The Dull/Backward child. This group included special class candidates (those with an IQ of 70 to 85) and children of average intelligence who still experienced difficulties at school.
- 3) Delinquents; those children manifesting early signs of criminality such as stealing, excessive lying, bullying, truancy and sex offences.
- 4) Neurotics. This included: (i) personality problems, e.g. timidity, obstinacy, shyness; (ii) behaviour problems, e.g. temper tantrums, food fads, wandering; (iii) psychoneuroses, e.g. hysteria, anxiety states, phobias, obsessions; and (iv) habit disorders, e.g. thumb sucking, nail biting (Minde, 1937a).

This classification follows that of Henderson and Gillespie's 1932 Textbook of Psychiatry, which indicates the wide systematization of the field of childhood pathology already available at that time (Rose, 1985). The first two categories correspond to those children referred to previously as "deviate" within the educational system, who needed to be assessed as regards their intellectual functioning. The last two categories refer to those children labelled as "maladjusted" and who required intervention before any difficulties developed into major social problems.

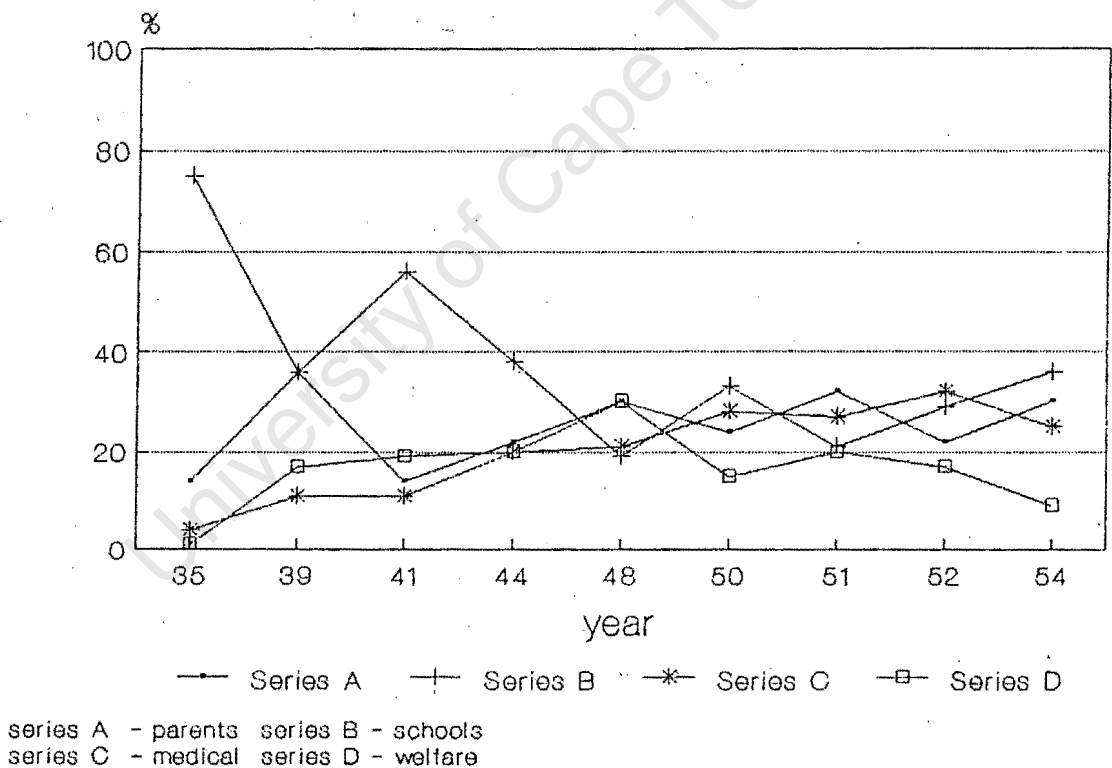
The types of problems mentioned above emerged first and foremost at the school where comparisons between children were made possible

on a large scale. This is substantiated by considering where the children who were sent to the Clinic came from.

Referrals were received from schools, parents, doctors and medical institutions, as well as welfare agencies. The referral percentages for each source calculated from 1935 to 1954 are presented graphically in Figure 1.(7)

FIGURE 1

REFERRAL SOURCES - 1935 to 1954



Initially, from 1935 to 1939, school referrals constituted 75% of Clinic cases, and between 1941 and 1943 more than 50% of the referrals came from the schools. This referral source continued to

constitute a substantial proportion of the cases investigated. In 1954 36% of the Clinic's total cases were referred from schools. Other referral sources, especially that of parents between 1939 and 1944, increased steadily over the ensuing years, and from 1948 onwards there was about an equal percentage of referrals between all referring agents. The large percentage initially referred from schools, the rapid growth of referrals from parents between 1939 and 1944, and the equal percentages from 1948 onwards, therefore are the outstanding features of this graph.

This high percentage of school referrals in the first years helps to substantiate the hypothesis underpinning this section, namely that psychology was initially ensconced in education. It has been argued that the Clinic was established as a site of psychological practice, as a consequence of issues posed within this field. The Clinic, and in particular the psychological staff within the Clinic, fulfilled the required role of identifying, assessing and dealing with these educational problems. The types of children sent to the Clinic, the large percentage of school referrals and also the importance placed on testing in the early years of the Clinic, lends support to this hypothesis.

The Clinic continued to address educational issues as will be demonstrated in the ensuing sections. In considering the history of the Clinic, however, what also becomes evident is the growing expertise that the psychologist was assuming in a number of areas. This topic is developed in the following section.

THE INCREASING ROLE OF THE PSYCHOLOGICAL EXPERT

"The doctor, before he is permitted to treat his patients, must devote six years to the study of medicine; the lawyer, before he can defend his client, must be articled for five years;.....Yet we calmly allow two young people without any previous training whatsoever to undertake the arduous and responsible task of bringing up our future citizens, quite satisfied that the inexperienced parents are endowed with an instinctive knowledge of the way to bring up their young.....".
(Minde, 1937a, p. 26).

This section focusses on the general procedure followed and the work of the Clinic in more detail. It is argued that a psychological way of understanding and dealing with problems developed and that this psychological knowledge is what formed the basis of the psychologists' claim to expertise. The particular areas involved and how they changed and increased in sophistication over the years will be explored.

In order to address how problems came to be viewed from a psychological angle, it is necessary to reconsider the strategies deployed in the Mental Hygiene Movement. Rose (1985) describes the underlying interventive strategy in Britain as a psycho-social one. Dual emphasis was placed on the early detection of minor problems in the individual child as well as on investigating the mental hygiene habits of the family. The family, like the child, was therefore regarded as an object of investigation and intervention. Within child guidance work, the family and psychological work converged (Rose, 1985).

According to Rose (1985), the family's implication in relation to the problems of childhood influenced child guidance work in Britain

and America in three particular ways, namely:

(1) Emphasis was increasingly placed on the role of the family as the determining factor in children's problems. The family continued to retain its importance over time, but the conception of the role played by the family changed as the body of psychological knowledge increased. For example, the family was initially regarded as the training site for the inculcation of good habits in the child.

Later the emphasis shifted to the emotional realm, so that childrens' behaviour problems were regarded as indicative of problems within the family's emotional functioning.

(2) The increased focus on the family led to the necessity of a multi-disciplinary team to investigate the various aspects contributing to childrens' problems. Specialists in different fields were required to investigate the child so as to obtain an overall picture of the "whole" child. Thus the services of a doctor, social worker and psychologist were required.

(3) The focus on the family as the site of pathology necessitated educating parents and the general public as to what constituted mental health and the ways in which it could be promoted. Texts, written by so-called experts in the field of mental hygiene gave advice to parents on how to train and rear their children, often citing scientific findings in support of their claims. The writings of Freud were popularized, concentrating on a practical rather than theoretical outlook, while Watson's treatise The psychological care of the Infant and Child (1928) is summarized by Lomax (1978) as "a tirade against the natural ineptness of mothers and a plea for systematic training in childrearing" (Lomax, 1978, p. 120).

The above three themes are considered in relation to the Cape Town Clinic in the ensuing pages. The procedure followed at the Clinic until 1956, as outlined initially, provides a general descriptive framework within which to illustrate the multi-disciplinary approach used at the Clinic, the importance attached to the family as a source of "maladjustment", the types of assessments done, and the dominant position occupied by psychologists at the Clinic.

The general procedure as outlined in the Annual Reports remained more or less constant until 1956. It was recommended that the child be accompanied to the afternoon session by one or both of the parents. Parent(s) and child were then interviewed separately by the psychologist assigned to the case. The child was given a physical examination by a medical doctor and the psychologist administered a routine intelligence test (Annual Reports, 1939 - 1940).

It has already been argued that intelligence testing constituted the psychologist's particular contribution from the beginning. In fact, up to 1940 intelligence tests were given to all children no matter what the reason for referral. After 1940, this became more flexible, as psychological interest shifted from the cognitive to the behavioural realm (see below).

The Annual reports make it clear that psychologists at the Clinic made a number of concerted attempts to move away from the initially defined role of administrator of intelligence tests, towards that of the behavioural realm. For example, the Annual Report for 1950-1951

makes a statement excluding children referred for an assessment of intelligence only, and states further that the Clinic is available for behavioural problems of all types. This statement coincides with Taylor and other members of the Psychology Department's involvement in behaviour modification and Wolpe's work in particular. However, it is interesting to note that from 1935 to 1971, an average of 93% of children attending the Clinic were given intelligence tests annually, no matter what the stated reason for referral. This points to the extent to which the psychologists' role has been defined and restricted as the administrator of tests.(8)

Since these tests played such a central part in the activities of psychologists at the Clinic, they need to be considered a little more closely. Terman's Stanford Revision of the Binet-Simon Test was used from 1935. The Progressive Matrices test, which had been standardized in South Africa in 1941 (O'Meara, 1983), was used as a supplement, together with Cattell Intelligence Tests (Annual Report, 1939 - 1940) and the Merrill-Palmer (Annual Report, 1941 - 1943). The Clinic used mainly those English tests standardized on overseas populations. It is interesting to note that while the Afrikaans version of the Fick Intelligence Scale was used from 1941 (Annual Report, 1941 - 1943), no mention is made of the use of the English one. The Fick Scale was based on Spearman's two factor theory. It appears that the Psychology Department aligned with Thurstone's views in the contemporary Spearman/ Thurstone debate regarding the factors constituting intelligence (Rees-Davies, 1930), and this may account for this notable omission. In the Annual Report 1944 - 1946

reference is made to the Clinic staff devising and standardising their own test battery which was said to take into account "the multiple factors constituting intelligence". This test battery included scholastic tests so as to also assess scholastic abilities in school subjects. It provided the basis for Dr. H.W. Smith's Ph D in 1945.

Once the testing had been completed, in terms of the procedure at the Clinic, all information was pooled for discussion at the weekly staff meeting held on a Saturday morning. If it was felt that further information on the child and/or the family was required, it would either be requested that the child return for another session, or the home visitor would visit the family to gather the relevant social and family information. Home visits were regarded as important sources of information at the beginning. Between 1939 and 1940 "home maladjustment" was estimated as being an important factor in 40% of the children referred, while 44% of cases received home visits from the home visitor (Annual Report, 1939-1940).

An explanatory remark must be made about this category of expertise. The home visitor at the Clinic, the first one being Dr. E.M. Thompson, was also a member of the psychological staff. The lack of reference to social work in the Annual Reports until 1957 attests to the initial slow development of this profession in South Africa even though there was an obvious need for it. During the 1930s social work was still in its embryonic stage, as indicated by the fact that two American sociologists needed to be imported for the first Carnegie Investigation into Poverty in 1929 (Louw, 1986).

While Minde (1937b), in his address delivered at the 1936 Social Work Conference, makes reference to a social worker at the Cape Town Clinic, this is not validated by the Annual Reports. Home visiting, as well as testing, is acknowledged as falling within the psychologist's area of expertise.

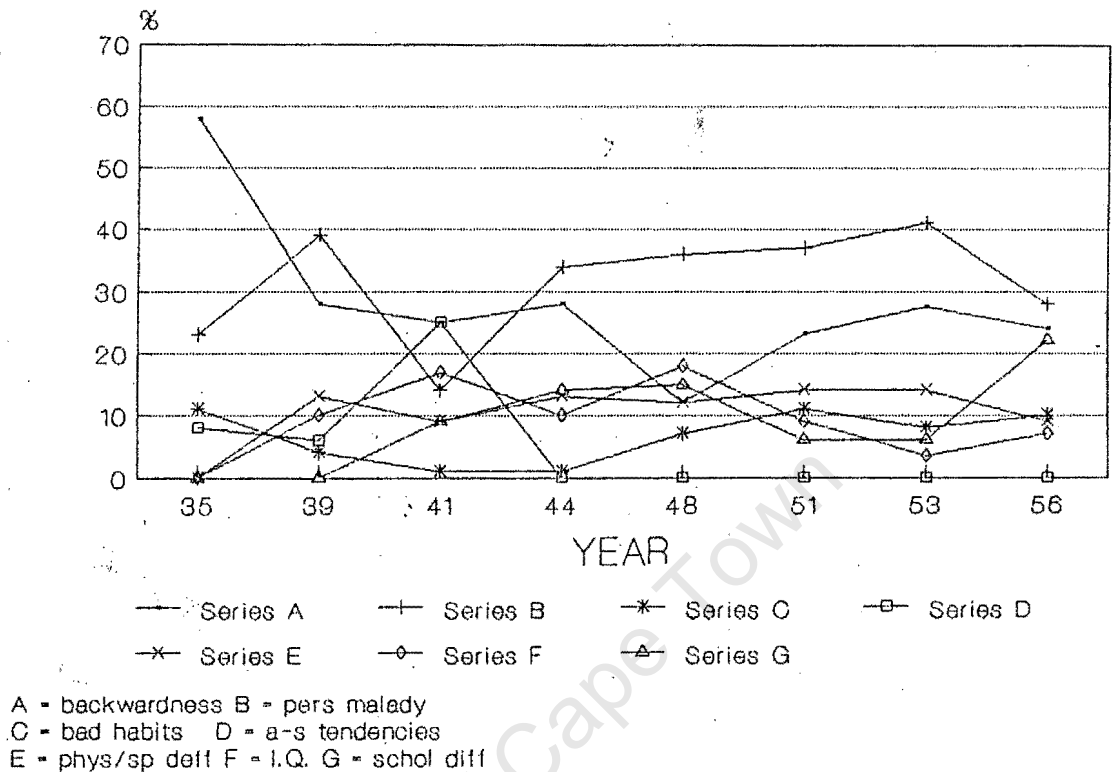
Once all the information from the various team members had been gathered together, a diagnosis was made and a plan of treatment drawn up (Annual Reports, 1939 - 1956). The use of the words "diagnosis" and "treatment" denote a clinical stance to the psychologists' work, heavily influenced by the medical way of thinking. It too marks an imperceptible shift towards that of a specialist or expert role for the psychologist.

This becomes more evident when considering the classificatory systems used. The categories depicting referral reasons underwent three major changes, that is, from 1935-1957, 1957-1967 and 1967-1971 respectively. These are represented graphically in Figures 2, 3a, 3b and Figure 4.

As an explanatory note, Figures 3a and 3b together comprise the categories used in the 1957-1967 classification. Due to the large number of categories listed, it has been necessary to use two graphs in order to depict the categories clearly. Nevertheless, these graphs will be treated as one in the discussion.

FIGURE 2

REASONS FOR REFERRAL - 1935 to 1956



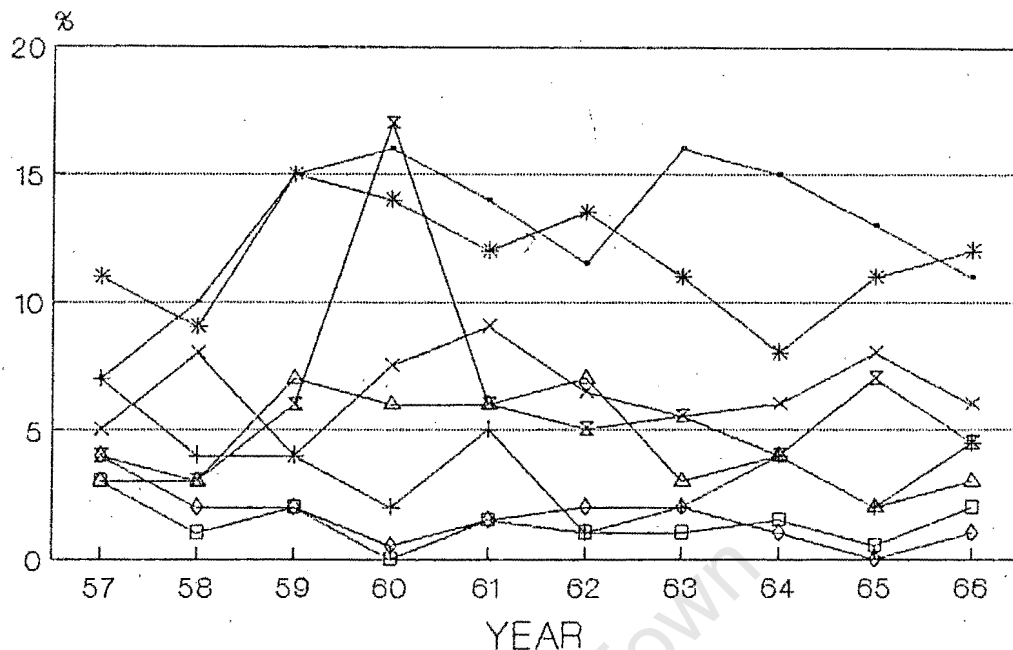
In 1935 four main reasons for referral were given, namely backwardness, bad habits (such as thumb sucking, enuresis), anti-social tendencies (truancy, stealing) and personality maladjustment (day-dreaming, aggressiveness). As has been referred to earlier, these descriptive terms imply some normative judgment: one in the intellectual realm, the others in what can be referred to as the behavioural or emotional realms interchangeably. In 1940 a category physical/speech defects was added and a year later two further scholastic categories, namely scholastic difficulties and requests for IQ assessment. At the same time the category anti-social tendencies disappeared, to be incorporated into personality maladjustment.

Certain trends are discernible. In the scholastic arena the addition of categories, together with the decrease in referrals for backwardness, implies that scholastic problems have, with time and increased knowledge in the area, become more differentiated and refined. One can speculate that a child experiencing difficulties academically was no longer merely explained away as "backward". The category request for IQ assessment may also indicate a growing awareness by the public of what the Clinic could offer them.

In the behavioural realm, there is a gradual increase in referrals for personality maladjustment, and from 1944 to 1956 it constituted the largest referral reason. This points to a shift in thinking towards the psychological/emotional domain. The incorporation of anti-social tendencies into the personality maladjustment category provides clear evidence of the changes in viewpoint regarding delinquency and 'anti-social' symptomatology. These behaviours, such as stealing, instead of being regarded as precursors to a life of crime which must be prevented, have now shifted to a symptom of maladjustment. This indicates a move to a more psychological way of viewing the problem. Stealing begins to represent a psychological symptom which, as noted previously, invariably indicates some form of pathology within the family, rather than merely aberrant behaviour.

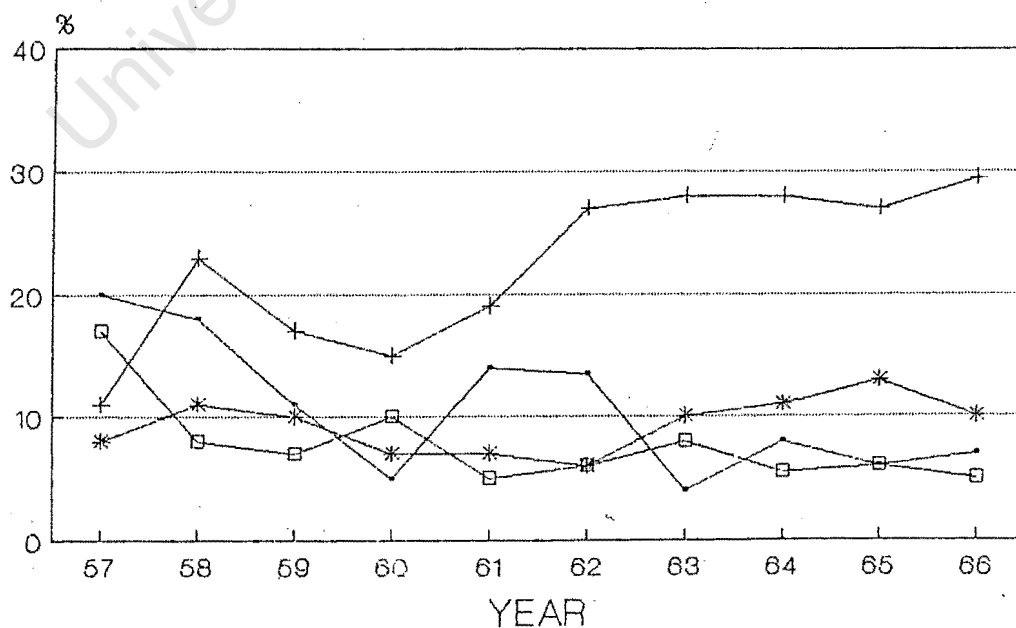
Categories changed again, both in (1957 to 1966) and in (1967 to 1971). These changes are depicted in Figures 3a, 3b and Figure 4 respectively.

FIGURE 3^a 25
REASONS FOR REFERRAL - 1957 to 1966



— Series A + Series B * Series C —□— Series D
 —x— Series E —◇— Series F —△— Series G —x— Series H
 A: Aggressive/hostile/non-conforming behaviour at home
 B: Aggressive/hostile/non-conforming behaviour at school
 C: Anxious/nervous habits/fears D: Sex problems
 E: Routine training problem: feeding/sleeping/toilet
 F: Psycho-somatic complaint G: Delinquent acts, e.g. stealing
 H: Advice with regard to placement/education

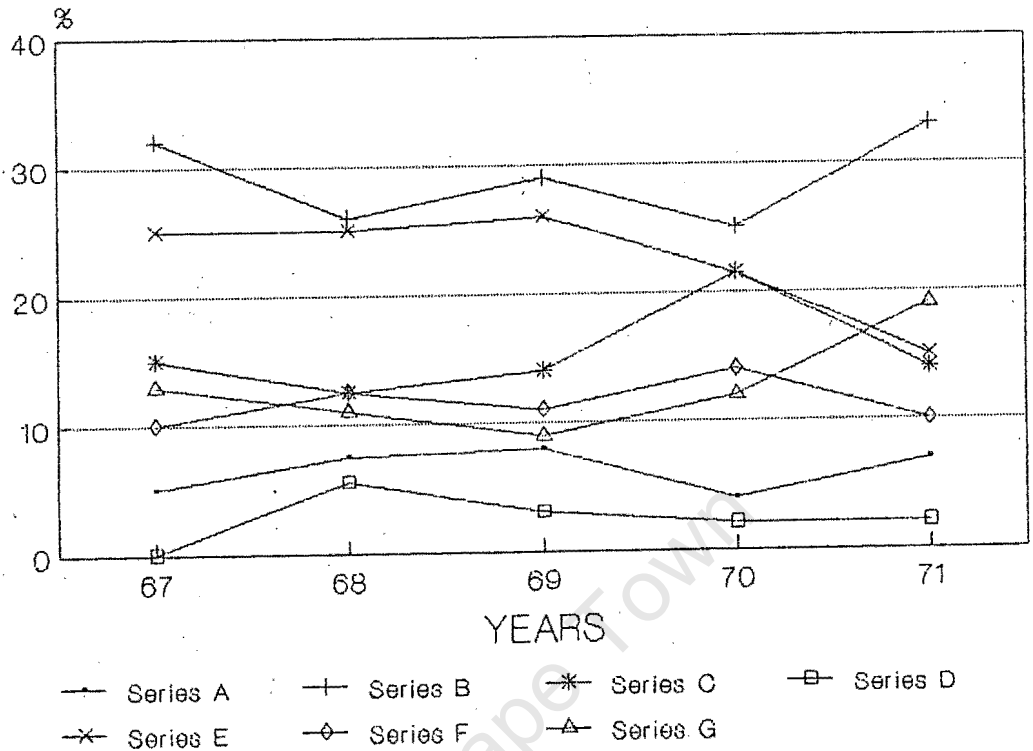
FIGURE 3^b REASONS FOR REFERRAL - 1957 to 1966



A - gen retard B - poor prog schl
 C - schl disabl D - phys/speech

FIGURE 4

REASON FOR REFERRAL - 1967 to 1971



A: Suspected mental deficiency B: General poor progress at school
C: Specific scholastic disability D: Physical/Speech defect
E: Non conforming, aggressive behaviour at home or school
F: Nervous habits, fears, anxieties
G: Multiple, generally stated problems

While these referral reasons indicate the consistently close relationship that the Clinic had with the educational field, they also point to the increased growth of knowledge within the psychological realm that has already been alluded to.

In both classifications the 'scholastic' referral reasons remain the same. However, the earlier class scholastic difficulties is differentiated further into that of poor progress at school and, a new, specialised term, scholastic disability. This was an important area of expertise to the psychologist, especially with regard to its

diagnosis via testing. Similar to the trends noted previously, referrals for general retardation gradually decreased while poor progress at school became a major referral reason.

The 1957-1967 and the 1967-1971 scholastic trends summarized here suggest the following:

(i) the Clinic's initial major concern was with the differentiation between mental handicap and the child of average intellectual ability.

(ii) This became more discriminative, e.g. differentiating out a special class candidate and children with physical handicaps, e.g. speech problems. The physically handicapped children were later referred on to other fields, usually the paramedical, which were also becoming more specialized.

(iii) During the 1960s emphasis was placed on the detection of finer disabilities, e.g. reading disabilities.

In the 1957-1967 classification, categories reflecting emotional problems doubled in number and became more circumscribed. On the one hand this indicates an increasing specialization and differentiation of childhood pathology, and hence the growth of psychological knowledge in the emotional arena. This is attested by the inclusion of a category like psycho-somatic complaints which did not appear as a psychological problem twenty years earlier. On the other hand other particular descriptions used, as for example, routine training problem (with the emphasis on routine) and the new category advice requested also point to a general shift in focus from the study and treatment of the abnormal to that of the normal.

Rose (1985) considered the particular emphasis placed on the environment and the plasticity of the young child by the psychological theories espoused after World War I, as one of the main reasons for this shift. As highlighted earlier, the most important experiences for the child were regarded as those emanating from the family. Psychological maladjustment was due mainly to disturbances occurring within this family environment and intervention was geared at advising and guiding parents as to the "correct", normative way to treat their children.

With the shift in attention to the psychological realm, the sharp dividing lines between what was regarded as abnormal and what was not, became less distinct. For example, a certain behaviour, such as nightmares, could be regarded as within the range of normality, depending on the child's age and the particular circumstances under which it occurred. This may account for the return to more generalised descriptions in the 1967 categorization. This parallels the shift of interest to the study of the normal and the concomitant collection of normative data on child development which characterized child psychology in the middle of this century.(9) As a corollary to this shift of interest to the normal, parents were now being advised as to how to promote adjustment and prevent maladjustment (Rose, 1985).

At this point a comment on the type of treatment offered at the Clinic is necessary. During the first twenty years this was mainly educatory and advisory.(10) Parents and other referral sources were advised as to how to cope with the child's particular problem.

Initially this was done via a letter; from 1957 onwards advisory interviews were conducted with the referring agent.

Most of the advice was of a commonsense nature. As an example, Minde (1937a), outlines the situation of an intelligent boy referred to the Clinic for a blinking habit which developed soon after his parents curtailed his sporting activities after an illness. Treatment consisted of advising the parents to send the child to a boarding school and to increase the difficulty of his schoolwork. Needless to say the blinking disappeared. (11) What stands out from the nature of the advice given is how commonsense appeared to take on more meaning when ratified by science and provided by an expert in the psychological field. How to rear children became an issue within the sphere of the psychologists' expertise whose knowledge was grounded in so-called sound scientific findings.(12)

Again one sees how a more general educative or informative role is envisaged for the Clinic. After all, parents, schools and the general public needed to be educated as to what these sound principles of child rearing were. This issue of "the public and its knowledge" will be addressed in relation to the popularization of psychology by the work of institutions such as the Child Guidance Clinic.

There is evidence that the Clinic popularized its psychological services and attempted to educate the general public both as to what constituted psychological problems and how to promote adjustment in children. The book, In search of happiness, written by Minde (1937a), the Clinic's first Honorary Psychiatrist, is an example of

the popularizing psychological literature of the time. The book includes chapters on the various psychological problems of childhood, of which sections were also published anonymously in the Cape Times. This is indicative that it was aimed at the public at large. One chapter addresses itself to The Child Guidance Clinic, to "....point out its value to parents, schools, and the community at large" (Minde, 1937a, p. 98).

Between 1958 and 1960 numerous study groups for parents and professionally interested people were held at the Clinic in conjunction with the Cape Town Association of University Women. Courses covered topics such as "The Pre-School Child", "The Junior School Child" and "The Adolescent". One of the courses was held in the evening especially so that fathers could attend. Public talks were given to organizations and Parent Teachers' Associations. Mention is also made of a series of papers on "Psychology and Mental Health" delivered to the Cape Town branch of the Union of Jewish Women in 1966. A certain number of local PTAs; among them Greenfields, Rustenburg and Stepping Stones Nursery School, are consistently thanked in the Annual Reports for their donations.

Schools were therefore also informed as to the correct psychological practices and the latest findings. They were similarly encouraged to help educate parents, both about the importance of mental health, as well as on what were considered appropriate referrals at the time. An example is the following, in the Annual Report for 1941 - 1943:

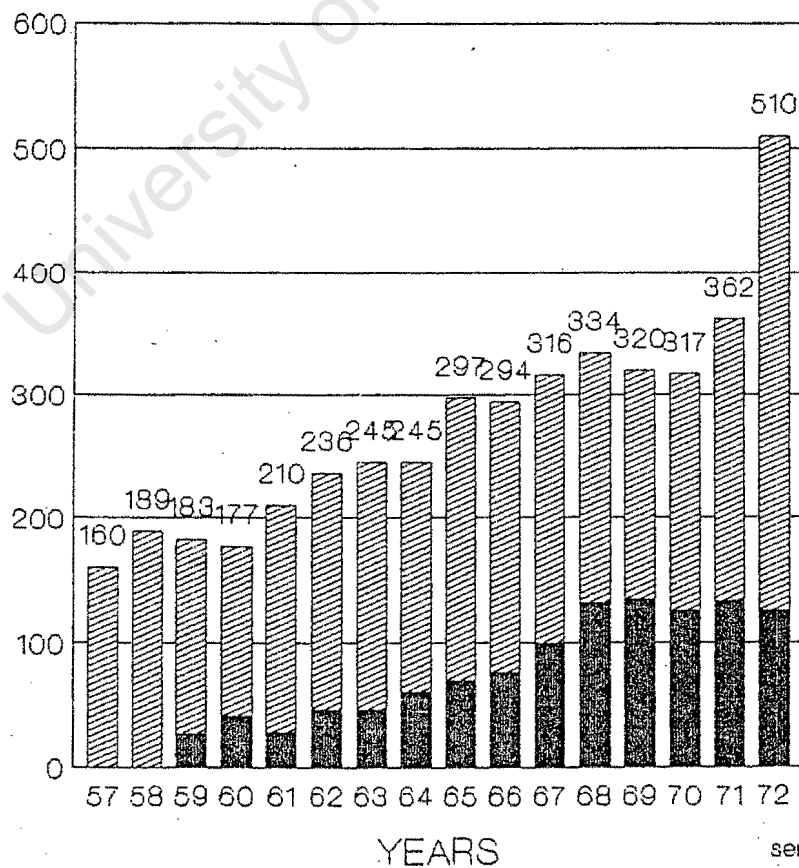
"We have still to combat very frequently the general and quite erroneous impression that this Clinic is primarily

for mentally retarded children.....We should be grateful for the help of the Principals of Schools in this connection, and hope that they will be able to educate their "parents" up to the idea that the psychological study of children is in many cases as necessary as their medical inspection and does not, any more than does such inspection, denote sub-normality."

An analysis of data obtained in the Annual Reports indicates that the general public, and parents in particular, were in fact educated as to the usefulness of the Clinic. The increase in the number of cases attending the Clinic annually from 1957-1972 illustrates the increasing use made of the services offered by the Clinic. This is illustrated graphically in Figure 5. Data has only been taken from 1957 and onwards as the data concerning case numbers in the earlier reports are not consistently reported.

FIGURE 5

NO OF CASES SEEN AT CLINIC:1957 to 1972



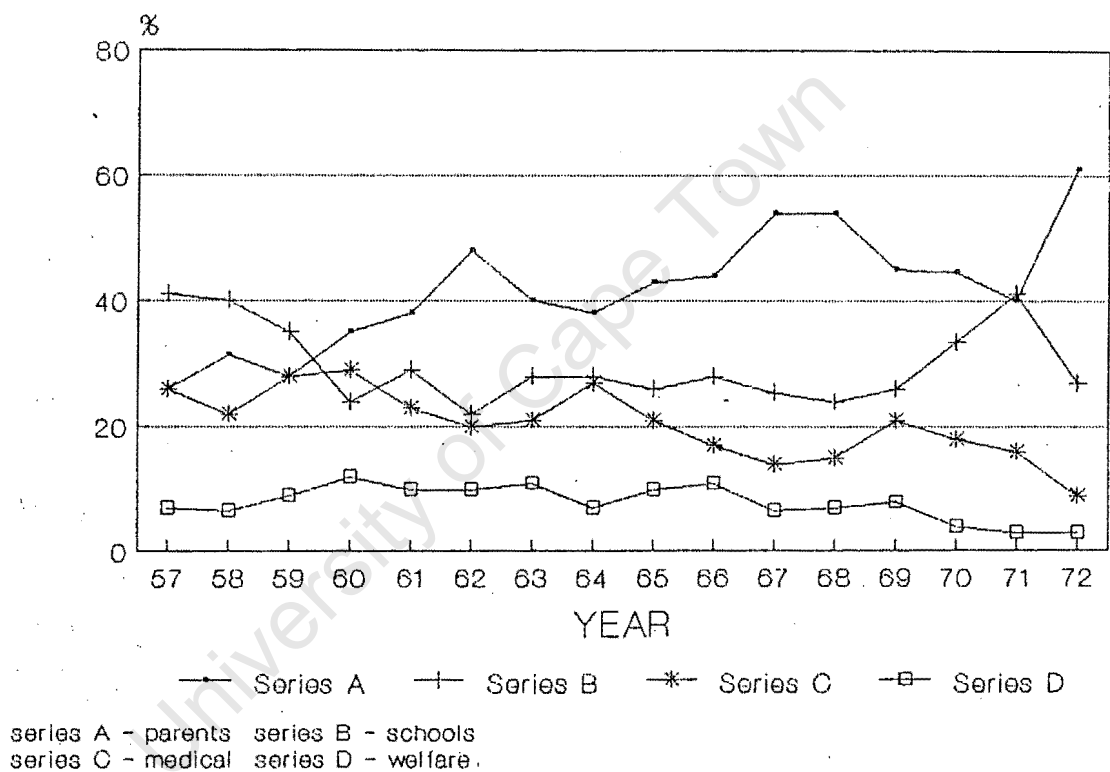
series A = continuations
series B = new cases

Series A Series B

Similarly, the use made of the Clinic by parents in comparison to other referral sources increased dramatically since 1957 again. The referral sources and the annual percentage of referrals from each source from 1935-1972 is illustrated graphically in Figure 6 (see also Figure 1).

FIGURE 6

REFERRAL SOURCES - 1957 to 1972



It is speculated that the steady increase of referrals from parents indicates three possible inter-related trends:

- (1) Parents were becoming more psychologically minded in the way they reared and related to their children.
- (2) Parents and the public in general were becoming increasingly aware of what constituted a psychological problem.
- (3) Parents and the general public were becoming increasingly aware of the specialised services offered by the Clinic.

It was argued in this section that the Clinic came to be regarded as a specialized service by the community at large, both because of the efforts made at popularizing and because of an increase in the knowledge base of the psychologist. The general procedure followed at the Clinic and an analysis of data contained in the Annual Reports served to illustrate that psychologists were involved at the Clinic from its inception. They played a dominant role within the team, dealing with both the scholastic and the familial spheres of intervention. An analysis of changes within and between classificatory systems indicated an increasing differentiation and specialization and hence growth of knowledge within both the scholastic and behavioural realms. A further shift towards the study of the normal was also noted. This allowed for the opening up of a wider area of study and practice for the psychologist.

The analysis of Clinic data indicates that psychology, in its applied and practical aspects, developed from within education, and has in fact continued to be involved in this field in South Africa. The years 1935-1971 in fact saw an increased expansion and a wider application of psychological knowledge in this and other domains, such as health and industry. With the increasing inclination towards practical and applied psychology, the issue of professionalization arose. This issue, as it relates to the Child Guidance Clinic, is outlined in the following section.

WORLD WAR II AND THE PROFESSIONALIZATION OF CLINICAL PSYCHOLOGY

This section aims to demonstrate the phenomenal developments within the Clinic during the 1950s against the background of the growth of clinical psychology in South Africa at this time.

Clinical psychology in South Africa developed somewhat later in comparison to its growth in the USA and Europe. In these countries, clinical psychology, of all the "applied" psychologies, grew the fastest. In America it was established on an organisational level within the American Psychological Association soon after World War II and training programmes were started at Ph D level with government aid, in conjunction with universities (Garfield, 1965).

The Second World War is generally regarded as an important catalyst for psychology moving out of the universities. Parker (1986) summarizes the effects of the war on the growth of clinical psychology as follows:

- "(1) a need for large-scale screening/assessment programmes to determine appropriate placement of troops;
- (2) a need for large-scale treatment services for psychological casualties of the war;
- (3) a need for psychologists to undertake a more psychotherapeutic role to fulfill massive demands psychiatrists were unable to cope with;
- (4) a placement of more emphasis on research methods in an applied setting...." (Parker, 1986, p.33).

In South Africa, generally speaking, the World War II provided a similar impetus towards psychology moving out of the academic arena. For example, the Aptitude Test Unit of the South African Airforce was established, which was transformed after the War into the National Institute of Personnel Research (O'Meara, 1983). These

developments, however, were related more to industrial than clinical psychology (O'Meara, 1983; Skawran, 1968).

As a result of these developments, and the concern of the Medical Association of South Africa over (very few) psychologists entering the health domain, there was increasing concern over the registration and qualifications of psychologists. This concern dominated South African psychology during the 1950s, after the South African Psychological Association was established in 1948 (O'Meara, 1983). In 1955 voluntary registration with the South African Medical and Dental Council was eventually effected for those psychologists working in the area of mental health. Qualifications stipulated were: a Master's degree in Psychology and one year's practical experience in psychological procedures at an approved institution (The South African Medical and Dental Council, 1955). Educational and personnel psychologists' training requirements, as stipulated by SAPA, was a degree in Psychology, some specialized training, and practice under supervision. This register of SAPA was also voluntary, the reason being that, until 1965, there were no professional training courses in psychology offered by the Universities (Psygram, 1959).

The 25 years following World War II were thus characterized by a concern to establish and accord psychology full professional status. As a consequence, attention was focussed on establishing training facilities in order to consolidate the emerging profession (Grover, personal communication).

The Cape Town Child Guidance Clinic was an ideal setting for the promotion of this objective, particularly as it occupied an appropriate position between university and practice. This intermediate position provided an ideal site for the emergence of contemporary professional issues, such as the development of new techniques and new knowledge in psychology, as well as research and training.

With these objectives in mind, the Clinic was officially incorporated into the University in 1957. The Annual Reports for 1957 and onwards outline the Clinic's functions, in order of priority, as those of training, research and then service to the community. The building that was erected was specifically designed to offer facilities both for lecturing/training as well as for practical work with children and families.

In line with the general expansion, new specialists gradually filtered into the Clinic, during this period by way of people offering their services in voluntary capacities. An occupational therapist who did group activities with the children was noted in the Annual Reports for 1959 and 1960. Social work per se was eventually mentioned for the first time in 1957 and the services of an honorary psychiatric social worker were made available.

The first full-time staff position created was that of a clinical assistant/clinical psychologist in 1958. It is notable that the Annual Reports mention the difficulty in finding a suitably qualified person initially. This strengthens the contention that clinical psychology developed quite late in South Africa, which

furthermore is indicative of the lack of training facilities available in South Africa at this time. According to the Annual Reports the new post of clinical assistant allowed for more in-depth work with children. This is also noteworthy as psychotherapy was made available as one of the two forms of treatment offered, the other being that of remedial teaching.

It is worthwhile to pause and consider these treatment regimes in the next few pages. While they do not constitute the entirety of the Clinic's work at this time, they provide good examples of the Clinic's ability to amalgamate clinical practice with that of research, thus making the Clinic an ideal site for clinical training in the form of an "apprenticeship"/internship. The application of both remediation and psychotherapy allowed for practical intervention in the form of assessment/diagnosis and treatment, as well as data collection and the construction of clinical knowledge within these spheres.

Remedial teaching had already been started in a small way in 1954. This was a particular area of interest to Dr. Grover who had been introduced to the concept when she visited America, as well as to a Miss Raath, who had been involved in education as Dr. Reyburn's research assistant in the Department (Grover, personal communication).

Initially a small number of children who were having difficulties in basic school subjects were assessed and given special tuition. In 1957 remedial teaching was given a research focus as well. The 1957 Annual Report mentions a Remedial Centre at the Clinic, the aim

being to develop new techniques and methods of diagnosis and treatment, as well as to study the causative factors of reading and spelling disabilities. The remedial focus allowed for the collection of clinical data on learning disabilities: a paper written by Dr. Grover on the nature of reading disabilities was published in the Journal for Social Research in 1964. The Centre also collected normative data so as to assess lags in spelling and reading attainment; the UCT Reading and Spelling Tests were devised at the Centre (Rosen, 1960). A method of group remediation was applied to children who were behind in this regard. This served as a topic for another publication, also in the Journal for Social Research in 1964.

As a result of the research conducted at the Clinic, early recognition and early treatment of scholastic disabilities was stressed as a finding. According to the Annual Reports the demand for remedial services increased to such an extent over the years that a full-time Remedial Teacher, Mrs Minnaar, was employed in 1963. Another part-time remedial teacher had to be employed in 1966.

The focus was not only on research and treatment; the Centre also had repercussions in the field of training in remedial teaching. In 1961, a course with the emphasis on scholastic disabilities and remedial teaching, was given at the Clinic to students studying for the Diploma for Teachers of Speech and Hearing Handicaps and the Diploma for Special Class Education. The need for specially trained remedial teachers at schools was constantly stressed. In 1972 the Educational Departments at Stellenbosch and Cape Town University

introduced a new course, the Diploma in Remedial Education (Annual Report, 1972). Students studying this course at UCT did practical work at the Clinic.

The other form of treatment offered from 1957 onwards was psychotherapy. This was in line with the growth of clinical psychology at the end of the 1950s (O'Meara, 1983). Psychotherapy was a relatively new aspect of the role definition of the clinical psychologist (Parker, 1986). This further strengthens the point that local practices were following closely behind that of international developments.

When the new building was built, rooms were designed specifically to accommodate both individual and group therapy. Group therapy was a relatively new innovation which was in vogue during the 1960s. Dr. B. Stoch carried out a group diagnostic observational study on children at the clinic for her doctoral dissertation. The research was aimed as being an aid to formulating therapy programmes and both social learning theory and ego psychology were used to inform the behavioural observations.

According to Dr. Grover (personal communication), the type of therapy offered depended both on the nature of the particular problem and what therapeutic skills and type of expertise were available at the time. During the early 1960s the major theoretical stance at the Clinic was that of learning theory. This was not surprising: it was indicated earlier that it was also the main orientation within the Psychology Department at the time. Dr. A. Abramovitz, who shared the part-time Clinical Assistant post at the

Clinic with Mrs R. Rosen from 1963 to 1969, is recalled as being a staunch behaviourist at the time (Grover, personal communication). Again, one needs no reminder of the work of J.G. Taylor in the department, who had such an important influence on Joseph Wolpe in the 1950s.

Wolpe's method of systematic desensitization constituted a new psychiatric therapeutic approach. It was regarded as a useful clinical method, especially for dealing with phobias (Abramovitz, 1963) and it was successfully applied in a number of cases at the Clinic in 1960 (Annual Report, 1960). In 1962 a paper by A. Schermann and Dr. Grover titled Treatment of children's behaviour disorders. A method of re-education, was published in Medical Proceedings. This outlined the application of a method based on Wolpe's learning theory principles on children, where the parent's role was also carefully defined.

Theoretical positions, however, always shift - often as new people join the Clinic/Department, or as new insights are gathered. The 1961 Annual Report refers to the Clinic constantly revising and improving on diagnostic techniques in the light of new theories and knowledge. In the later half of the 1960s viewpoints appeared to shift more towards a psycho-dynamic/ego psychology frame-work.

References are made to more and longer-term psychotherapy in the Annual Reports and the treatment of many cases was continued over into the following year. The rapid "takeover" of psychotherapy as a form of treatment can be gauged by considering the annual percentages of cases treated by this means. This increased steadily

from 1958 onwards; for example, 11% of cases were treated therapeutically in 1958, while this had risen to 22% in 1971.

The client population also increased dramatically between 1958 and 1972, as illustrated in Figure 5. This growth occurred in conjunction with the general expansion into research and clinical treatment.

Professional status required training facilities. The first internship training post in clinical psychology at Master's degree level was established before 1960 at Tara Hospital in Johannesburg (Parker, 1986). The first internship in child clinical psychology at the Clinic was made available in 1965. The next internship post was made available in 1968. It was doubled the following year and by 1971 the Clinic had three intern psychologists, who after an intensive four month training period in clinical procedures, became fully participating members of staff (Annual Report, 1971). At the same time the Clinic was made a field work placement for a number of advanced psychiatric social workers.

These developments coincided with training developments in psychology in the rest of the country. For example: the first clinical psychology internship post introduced by the Department of Health in 1967; and in 1968 a Master's degree course in clinical psychology was offered at the University of Natal (Parker, 1986). At the University of Cape Town the M. Sc. (Clinical Psychology) was officially started in 1972. The course was run in conjunction with Groote Schuur and Valkenberg Hospitals. Both the theoretical and

the practical side of the first year of the programme was offered at the Clinic (Annual Report, 1972).

The Clinic therefore participated fully in the post-War efforts of psychologists to consolidate the profession of psychology in this country. Its expansion in terms of research, practice and training paralleled major developments in clinical psychology in this country, such as issues of registration, training, forms of psychotherapy and the creation of internships. The Clinic played a significant role in terms of gaining social recognition and a more defined practical role for the profession.

University of Cape Town

Chapter 3

CONCLUSION

This study has attempted to address certain themes that characterize the emergence and subsequent development of the Cape Town Child Guidance Clinic from 1935 to 1971. These themes have been outlined under the following hypotheses:

- (1) Psychology was initially involved in education.
- (2) The psychologists' role expanded in conjunction with the psychologists' knowledge base.
- (3) With an increase in the practice and application of psychology, the issue of professionalization arose and as a consequence, training psychologists became important. Two further assumptions, namely that the Clinic's establishment and growth paralleled the rise and development of clinical psychology in South Africa, and that this development in turn mirrored developments elsewhere, were referred to generally throughout the study.

The first section of Chapter 2 demonstrated how the Clinic was established in order to assist with the identification and assessment of certain "problem" children. These problems were loosely defined as "educational" in nature, and the children were referred mainly from the schools. Intelligence testing formed the major part of the psychologists' role definition.

In the ensuing section, it was argued that the role of the psychologist expanded, and that the knowledge base from which psychologists operated, did likewise. An analysis of the general procedure followed in terms of assessment, classification and

treatment at the Clinic demonstrated that there was a psychological way of approaching and understanding problems, and that there was evidence that this was largely accepted by the general public (with the proviso of course that the Clinic drew its clients from a predominantly white, middle class group). Psychological expertise and knowledge developed over time and came to also include the study of the normal, as indicated by the changes in nomenclature in changing classificatory systems.

With the increasing practical and applied bent to psychology after World War II, the issue of professionalization and, as a consequence, training and internship, emerged. It was shown how the increased growth of the Clinic, both in its service and research functions, ultimately made it an ideal institutional setting for training in clinical psychology in South Africa.

To conclude on a methodological note: the study aligned itself with those historiographies viewing the practice of psychology from within a contextualist approach. More specifically, the study broadly followed Rose (1985), who traced the emergence and development of the modern enterprise of psychology in Britain. He argues that in Britain the "psychology of the individual" originated from within those areas where psychology's particular expertise could be used in relation to the abnormal, as opposed to the normal, functioning of the individual. He identifies the school as one of these areas, along with the courts, reformatories and the army. He argues that it was out of this initial attention to the study of the differences between and amongst people that the psychological interest in the study of the so-called normal arose.

The school thus provided the impetus for the development of an applied, clinical psychology. This led to the progressive institutional delineation of psychology and the establishment of institutions and departments specific to it. The practical application of clinical psychology necessarily required administrators, namely psychologists, trained by other psychologists. Thus the establishment of qualifications and the professional apparatus of psychologists emerged.

In this study the Child Guidance Clinic has been depicted as such a site of intervention in the educational domain. Between 1935 and 1971 it advanced from small, haphazard beginnings to having an organized institutional base within the Department of Psychology at the University of Cape Town. As such it was a site for the assessment and intervention of "problem" children and their families, conducted primarily by a group of "specialists/experts", the psychologists. It has been shown that the issues of professionalization and training in South Africa arose in conjunction with the increased growth of the Clinic. The Clinic was also implicated in the first avenues opened for the training of clinical psychology in South Africa.

It is argued therefore that the Clinic played a significant role, as an institutional site of psychological practice, in the development of clinical psychology in South Africa, and will continue to do so. As Reisman (in Parker, 1986, p.100), states:

"A history has no beginning and no end. Rather than being confined to indisputable boundaries, it is a record and an interpretation, carved and constructed with deliberation and judgement from all the available information concerning the subject."

NOTES

- (1) For further information on the topic, see Rose (1985), Chapter 3.
- (2) For an account of the Mental Hygiene Movement in South Africa see Minde (1975d). See Foster (in press) for an historical analysis of "feeble-mindedness" in South Africa.
- (3) While the Clinic was awaiting premises, cases were seen wherever suitable, either at the child's school, home or in the psychological staff's offices in the University. Apparently children and parents were personally met at Mowbray station by staff and driven to and from the University. From January 1937 to early 1939 the Clinic was housed in a wing of the Mowbray Public School (Annual Reports, 1935 -1937). This illustrates the humble, haphazard beginnings of applied and practical psychology.
- (4) The Annual Reports from 1935 to 1972 are used as a data base. The years are noted throughout the text but the reports are not listed under References. They can be obtained from the Cape Town Child Guidance Clinic, Mowbray.
- (5) According to Dr. Grover the cost of the new building amounted to R10 000. The building was officially opened by the seven year old son of the architect with the words "I am a child and I open this Clinic for children".
- (6) For a history of the rise and development of testing in South Africa, see Kriek (1968) and Minde (1975d). Foster (in press) also provides a synopsis of the rise of mental testing.
- (7) The writer is aware that bar graphs are normally used. However, in this instance line graphs depict trends more clearly.
- (8) See Rose (1985), for an interpretation as to why psychologists were unable to move away from this administrative role in Britain, pre-World War II.
- (9) This is outlined by Lomax (1978), Riley (1983) and Rose (1985).
- (10) Minde (1937b) discussed play therapy as a form of treatment at the Clinic and referred to the Cape Town Clinic as the first to offer this form of therapy in South Africa. However, according to Dr Grover (personal communication), there was very little therapy per se until 1957. According to her there was no space in the old Church to offer any specialised treatment.
- (11) See Minde (1937a) for further examples of case histories from Clinic material and for a summary of the particular advice given for specific problems.
- (12) For critiques on the psychologists' influence on child rearing practices and how they are influenced by the social, political and economic contexts, see Newson & Newson (1974) and Riley (1983).

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